REQUEST: NON-COMPETITIVE AMENDMENT

RECEIVED

MAR 0 4 2005

FISCAL REVIEW

APPROVED
Commissioner of Finance & Administration Date:

Each of the request items below indicates specific information that must be individually detailed or addressed as required.
A REQUEST CAN NOT BE CONSIDERED IF INFORMATION PROVIDED IS INCOMPLETE, NON-RESPONSIVE, OR DOES NOT CLEARLY ADDRESS EACH OF THE REQUIREMENTS INDIVIDUALLY AS REQUIRED.

RFS #	318.65-128		
STATE AGENCY NAME :	Department of Finance and Administration Bureau of TennCare		
SERVICE CAPTION :	Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management		
CONTRACT #	FA-04-15757-00	**PROPOSED AMENDMENT #**	2
CONTRACTOR :	First Health Services Corporation		
CONTRACT START DATE :	01/01/2004		
CURRENT, LATEST POSSIBLE END DATE : (including ALL options to extend)	12/31/2006		
CURRENT MAXIMUM LIABILITY :	$15,193,000.00		
LATEST POSSIBLE END DATE WITH PROPOSED AMENDMENT : (including ALL options to extend)	12/31/2006		
TOTAL MAXIMUM COST WITH PROPOSED AMENDMENT : (including ALL options to extend)	$37,900,000.00		

APPROVAL CRITERIA : (select one)	X	**use of Non-Competitive Negotiation is in the best interest of the state**
	☐	**only one uniquely qualified service provider able to provide the service**

ADDITIONAL REQUIRED REQUEST DETAILS BELOW (address each item immediately following the requirement text)

(1) description of the proposed additional service and amendment effects :

The amendment adds responsibility for a wide array of activities aimed at controlling costs and improving quality, including implementation of:
(A) TennCare reform (script limits, co-pays, OTC elimination), (B) Many new administrative and clinical edits (drug to gender, max dollar, gross amount due, prior auth criteria, max dose and dose optimization, unit of measure, MAC/DAW, DEA/Name, drug duration, drug to disease, drug-drug interaction), (C) A comprehensive retro DUR program; and (D) More aggressive MAC pricing. TennCare is also attempting to clean up/clarify some of the language in the existing contract, add considerably to the liquidated damages section as well as include a requirement to significantly increase the number of staff dedicated to the TennCare account.

(2) explanation of need for the proposed amendment :

This amendment will add responsibilities of First Health that will control cost and improve quality.

(3) name and address of the proposed contractor's principal owner(s) :
(not required if proposed contractor is a state education institution)

First Health Services Corporation
Teresa R. DiMarco, President
4300 Cox Road
Glen Allen, VA 23060

(4) documentation of OIR endorsement of the Non-Competitive procurement request :
(required only if the subject service involves information technology)

select one:	X	Documentation Not Applicable to this Request	Documentation Attached to this Request

(5) documentation of Department of Personnel endorsement of the Non-Competitive procurement request :
(required only if the subject service involves training for state employees)

select one:	X	Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

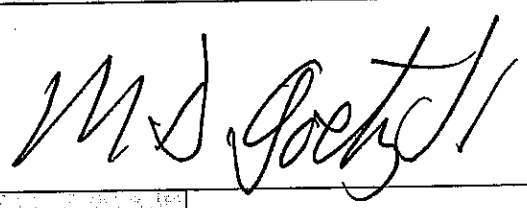
(6) description of procuring agency efforts to identify reasonable, competitive, procurement alternatives rather than to use non-competitive negotiation :

This contractor was identified as a result of Request for Proposal (RFP) which was issued by the Department of F&A. The current contract covers claims processing and PDL management. This amendment, however, adds responsibility for a wide array of activities aimed at controlling costs and improving quality.

(7) justification of why the F&A Commissioner should approve a Non-Competitive Amendment :

First Health Services Corporation was identified by competitive means as the contractor to provide Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management. The changes brought about as a result of this amendment will significantly improve services and reduce costs. The Bureau of TennCare would greatly appreciate favorable approval by the Commissioner of Finance and Administration.

AGENCY HEAD REQUEST SIGNATURE:
(must be signed by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR — signature by an authorized signatory will be accepted only in documented exigent circumstances)



SIGNATURE DATE:

CONTRACT SUMMARY SHEET

RFS Number:	318.65-128	**Contract Number:**	FA-04-15757-02
State Agency:	Department of Finance and Administration	**Division:**	Bureau of TennCare

Contractor	**Contractor Identification Number**	
First Health Services Corporation	X V- C-	540849793 03

Service Description

Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management

Contract Begin Date	**Contract End Date**
January 1, 2004	December 31, 2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.65	073	134	11	X on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2004	$1,453,500.00	$1,453,500.00			$2,907,000.00
2005	$4,757,822.00	$4,757,822.00			$9,515,644.00
2006	$8,487,366.00	$8,487,366.00			$16,974,732.00
2007	$4,251,312.00	$4,251,312.00			$8,502,624.00
Total:	**$18,950,000.00**	**$18,950,000.00**			**$37,900,000.00**

CFDA #	93.778 Department of Health & Human Services Title XIX

State Fiscal Contact

Name:	**Scott Pierce**
Address:	**729 Church Street**
	Nashville, TN
Phone:	**(615) 532-1362**

Procuring Agency Budget Officer Approval Signature

Check the box ONLY if the answer is YES:	
Is the Contractor a SUBRECIPIENT? (per OMB A-133)	x
Is the Contractor a VENDOR? (per OMB A-133)	
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	x
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractors Form W-9 Filed with Accounts?	x

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
END DATE →	12/31/2006	
FY: 2004	$2,907,000.00	
FY: 2005	$5,387,100.00	$4,128,544.00
FY: 2006	$4,589,100.00	$12,385,632.00
FY: 2007	$2,309,800.00	$6,192,824.00
FY:		
Total:	**$15,193,000.00**	**$22,707,000.00**

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

AMENDMENT TWO TO FA 04-15757-00, THE CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
BUREAU OF TENNCARE
AND
FIRST HEALTH SERVICES CORPORATION

This Amendment, by and between the State of Tennessee, Department of Finance and Administration, TennCare Bureau hereinafter referred to as the "State" or "TennCare" and First Health Services Corporation, hereinafter referred to as the "Contractor," is for the provision of Pharmacy Management and Preferred Drug List Services, as further defined in the "SCOPE OF SERVICES" is amended as follows:

1. **Amend Section A.1. by deleting the entire section and substituting with the following:**

A.1.1 **Program Enhancements**

Effective upon signature of this Amendment, the Contractor shall begin implementation of Program Enhancements and/or changes as directed by TennCare and as provided herein. Implementation shall be in three phases, Phase I, Phase II and Phase III. The start date for each phase is either (1) a date certain as shown on the chart below or (2) a number of days (as specified herein) after written notification by TennCare to the Contractor. The Program Enhancements in each Phase are set out below, including implementation deadlines. Many of these enhancements will result in telephone calls to the First Health Call Center. The Contractor agrees to staff the call center which is required under the Contract and operate it in accordance with the standards as required by Sections A.3.5.1 to A.3.5.3. Upon signature of this Amendment and as these enhancements become operational, TennCare agrees to compensate the Contractor for calls as outlined in Attachment B. The Contractor acknowledges that calls related to the preferred drug list ("PDL") are covered under the base contract and will not be reimbursed at the rates noted in Attachment B. The Contractor will assure that TennCare is not billed for such PDL-related calls and will submit monthly reports to TennCare detailing the numbers of resolutions associated with the PDL as well as the number of non-PDL related resolutions by edit and by type (technician, pharmacist or physician). Further the Contractor may not bill TennCare for any calls that are the result of an error or omission on their part in administration of the pharmacy benefit, including errors or omissions in the implementation of an edit.

Within thirty (30) days of signature of this Amendment, the Contractor and TennCare shall conduct a requirements session to develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each Program Enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.

Additional payment as agreed to by the Parties and as provided in this Amendment is the complete and whole compensation for implementation of the types of edits and services listed in the chart below. TennCare shall not pay additional implementation or pre-operational compensation in the event that additional, related edits are needed and which are reasonable, actual and necessary for the TennCare program,

Failure to meet deadlines as required herein, failure to provide reports or failure to implement Program Enhancements as required herein may result in liquidated damages and/or Breach by Contractor and are subject to remedies as provided in Section E.4. of the Contract. Prior to assessment of the damages provided in Section E.4, the parties

agree to discuss the pertinent issues and make a determination as to the reason or responsibility for the failure to meet the deadlines as required or failure to implement Program Enhancements as required. If there is a failure by TennCare which directly contributes to the failure by the Contractor to meet deadlines or provide reports, TennCare agrees that that will be a major consideration in assessing responsibility.

Phase I Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Script Limit Edits (see Contract Section A.2.2.3(i))	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Tiered Co-Pay Edits (see Contract Section A.2.2.4(c))	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Over-the-Counter Drug Coverage Elimination	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Step Therapy		Upon signature of this Contract Amendment Two	No later than May 1, 2005
Administrative Edits	Gross Amount Due Edit	Already Implemented	Already Implemented
	Drug to Gender Edit	Already Implemented	Already Implemented
	Maximum Dollar Amount Edit	Already Implemented	Already Implemented
	DEA Number Edits	Already Implemented	Already Implemented
Clinical Edits	Drug Duplication of Therapy Edit (see Contract Section A.2.2.9(a)(ii))	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	Drug Dosage & Dose Optimization Edit	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Additional Dedicated Staff	(1) Clinical Pharmacist based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(2) Provider Educator Pharmacists based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Pharmacy Research Scientist based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Data Quality	Upon signature of	No later than May 1, 2005

	Analyst based in Nashville	this Contract Amendment Two	
	(1) Systems Liaison based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Contract Manager based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Business Analyst based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) "Reform" Project Manager based 25% in Nashville, balance in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(2) Mail Room Clerks	Upon signature if this Contract Amendment Two	No later than May 1, 2005
Retro Dur	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005

Phase II Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Unit of Measure Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
	MAC/DAW Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
MAC	N/A	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

Phase III Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Prescriber Last Name Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
Clinical Edits	Drug Duration Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

	Drug-to-Disease Edit (see Contract Section A.2.2.9(a)(iii))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
	Drug-Drug Interaction Edit (see Contract Sections A.2.2.9(a)(iv) and A.2.2.9(a)(v))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

2. Amend Section A.2.1 by deleting the entire section and substituting with the following:

A.2.1 Retro-DUR Enhancements – Phase I Implementation

a. In addition to the responsibilities already required of the Contractor for the Retro-DUR program, the Contractor shall also assume an expanded role and shall implement a complete Retro-DUR program to be coordinated and maintained by a full-time Clinical Pharmacist dedicated to TennCare and supported by provider educators who are licensed pharmacists as well as eight (8) profile reviewers who are also licensed pharmacists. In addition, the Contractor's dedicated Clinical Pharmacist shall be responsible for the operation of the DUR Board including the recruitment of DUR Board members, with consultation from TennCare.

b. Description of the Operation of the Retro-DUR Program
The Contractor shall provide to TennCare all necessary components of a Retro-DUR program and shall operationalize those as follows:

i. Establish a Drug Utilization Review (DUR) Board, which shall require the following:

A. The Contractor's Clinical Pharmacist shall recruit and maintain a DUR Board composed of five (5) physicians, five (5) pharmacists, one (1) nurse practitioner alternating with one (1) physician assistant as suggested by the Contractor.

B. Selection of DUR Board members shall be based on medical and pharmacy expertise and willingness to serve in this capacity and provide the services specified by TennCare in writing. Members shall be required to be available for quarterly meetings and to review drug information and drug utilization materials as necessary to improve patient quality of care, to prevent fraud and abuse, and to control the costs of drug utilization.

C. The process of selecting DUR Board members shall incorporate suggestions concerning pharmacy providers from the Tennessee Pharmacist Association (TPA) and concerning physicians from the Tennessee Medical Association (TMA).

D. The Clinical Pharmacist shall consult with TennCare to obtain the approval by TennCare of the DUR Board make-up.

E. The primary role of the DUR Board is to provide program oversight and direction.

F. The Contractor shall send all DUR Board members a letter explaining that the responsibility for the Retro-DUR program is being transitioned to the Contractor and for new members a Letter of Appointment that shall specify lengths of terms, to be staggered.

G. The Contractor shall determine quarterly dates for the DUR Board meetings and determine the agenda for those meetings. Minutes for those meetings are to be taken by First Health Staff and shall be disseminated as appropriate. The Clinical Pharmacist shall prepare the following reports/information for presentation at DUR Board meetings:

1. TennCare utilizing-members data;
2. TennCare utilization by age demographics;
3. TennCare utilization by top ten (10) therapeutic classes determined both by number of claims and by payment amount;
4. TennCare top ten (10) drugs as ranked by claim count and by total payment;
5. Pro-DUR data including totals of Pro-DUR messages sent and savings associated with the top ten (10) drugs associated with each Pro-DUR edit;
6. Retro-DUR intervention analysis and cost savings information as associated with both member profile review and interventions and provider profile interventions;
7. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff;
8. Additional reports can be presented at the DUR Board meetings, as requested by TennCare.

ii. Recruit, maintain, and reimburse a panel of eight (8) clinical pharmacists to review member profiles. These clinical pharmacists shall each review one hundred (100) member profiles monthly so that a total of eight hundred (800) member profiles will be reviewed monthly, or a minimum of two thousand, four hundred (2,400) member profiles per quarter. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed.

iii. Provide TennCare read only access to First IQ™, a reporting tool to provide data analysis, profile production, letter interventions and tracking of all interventions, both letters and direct communication, to determine cost savings as related to the specific interventions accomplished. First IQ™ is also used to record intervention responses from providers. A number of reports, including Criteria Exception Estimates, Retro-DUR Profile Exceptions, Retro-DUR Intervention Analysis and Monthly Cost Savings, are reviewed and presented to the DUR Board and TennCare as determined appropriate by First Health.

iv. Maintain and update a set of clinical criteria in First IQ™ to be used in the profile production and exception processing program. Clinical criteria shall meet all CMS requirements and be developed and maintained to detect instances such as polypharmacy and related overutilization, underutilization, drug to drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a member's age or disease state.

v. Determine the focus for each of the four (4) quarterly provider profile runs and for each of the twelve (12) monthly member profile runs as determined by analysis of drug utilization in the TennCare Program. Additional topics as requested by TennCare can be reviewed as mutually agreed upon. The criteria used in the review process can be selected from the standard criteria or "forced", to review specific issues, as determined appropriate by the Clinical Pharmacist.

vi. Produce member profiles on a monthly basis, eight hundred (800) profiles per month or a minimum of two thousand, four hundred (2,400) member profiles per quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Typically, mailings are sent to prescribers or pharmacy providers but phone calls or visits can also be conducted as determined appropriate and/or upon the direction of TennCare. Mailings include an intervention letter to the prescriber or pharmacy provider detailing the reason for the intervention, a member profile to include details of previous interventions, medication history, medical claims data and any Pro-DUR messages sent to the pharmacy during claim adjudication. A response form is also sent in the mailing. The postage associated with these mailings will be reimbursed by TennCare as a pass-through cost.

vii. Produce provider profiles on a quarterly basis, two thousand, four hundred (2,400) profiles per quarter and determine appropriate interventions which are typically mailings to include a letter with recipient detail included and educational materials as appropriate. Telephone calls and/or provider visits might also be determined appropriate.

Unlike member profiling, provider profiles are not reviewed by clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed medication that meet criteria exceptions reviewed for the quarter.

The criteria used in the review process can be selected from the standard criteria or "forced" as determined appropriate by the Clinical Pharmacist. This program can also be used for Behavioral Health Organization prescriber notifications or in conjunction with any interventions requested by the Office of Inspector General.

Once criteria is selected and provider exceptions determined, interventions are to be in the form of mailings to include a letter descriptive of the issue reviewed, a provider profile of members who have excepted on the selected criteria, a provider response form, educational materials as appropriate, and a Provider "Report Card/Profiling Analysis." Direct interventions in the form of phone calls or visits can also be accomplished as appropriate.

Provider Profiling Reports that offer important information related to the quarterly reviews include, but are not limited to, a Provider Exception Report, Response Summary Report, and a Provider Profiling Audit Report.

viii. Report quarterly to the DUR Board on monthly member reviews and quarterly provider reviews to include interventions taken and responses and outcomes.

ix. Produce an Annual Drug Utilization Review Report for the TennCare program according to the annual CMS requirements.

x. The Board may request reports as needed to conduct business as provided herein.

c. Cost Savings Associated with Retro-DUR

Retro-DUR is focused on provider education through intervention to reduce inappropriate drug utilization and to improve clinical outcomes. Additionally, a well managed program shall generate cost savings through the alteration and improvement in prescribing and dispensing practices as well as the reduction in instances of fraud and abuse.

First IQ™ Retro-DUR cost savings are based on interventions (letter, telephone call, or face-to-face) with a provider (prescriber and/or pharmacy provider) related to a patient identified through a Retro-DUR profile review cycle. The intervention moves the case to the cost savings tracking system. The Therapeutic Class(es) related to the criteria involved in the exception, is captured and tracked. The average cost per day of the Therapeutic Class for the intervened patient is calculated based on a three-month intervention period. This cost is used as a comparative baseline figure in the monthly cost savings calculation. There is then a six (6) month waiting period before cost savings begin to be calculated, which allows time for the intervened provider to make the appropriate changes in therapy. Once the waiting period has elapsed, the average cost per day for the original therapeutic class is calculated based on the current utilization. This cost is then compared with the "baseline" cost and the difference is the cost savings (or cost increase, as the case may be in some quality of care interventions). This comparative calculation is systematically performed each month and the case is tracked for twelve (12) months. Each month a cumulative Retro-DUR cost savings is reported based on the active cases in the tracking system. This cost savings methodology provides TennCare with reasonable cost savings data as it relates to the Retro-DUR program.

3. **Amend Section A.2.2.1 by deleting the entire section and substituting with the following:**

A.2.2.1. Claim Adjudication Services - General Requirements.

This section defines claim adjudication requirements for all TennCare pharmacy claims regardless of source and including electronic batch, paper and POS claims. The timing of the adjudication shall differentiate POS claims from claims submitted in batch or on paper, however, all claims must be adjudicated through a common set of processing modules. All claims adjudicated as payable must be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of TennCare. All adjudicated and paid claims shall be transferred

weekly to the TennCare TCMIS by the Contractor. The Contractor shall distribute and mail TennCare outputs (hard copy and electronic) as directed by the TennCare Bureau including but not limited to provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of holiday weeks, for all claims submitted through the POS online pharmacy claims processing system up through the preceding Monday.

The contractor shall use first class rate for all client mailings. Mailing costs incurred by the Contractor shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the TennCare Bureau in addition to regular invoices and must include substantiating documentation. No overhead, administrative or other fee shall be added to such pass-through costs. Each batch must have its own reconciliation and money remits. The Contractor shall be responsible for system messages and notice of claims being adjudicated payable, denied or suspended.

a. Cash flow – For checks to be issued on Friday, the Contractor must deliver the following two files to the State, in an electronic media suitable to the State, by 10:00 a.m. Thursday of each week:

   i. all transactions (claims, financial adjustment, etc.) that comprise the payments to be issued for Friday of that week;

   ii. all payments (check register) to be made on Friday of that week TennCare shall be notified no later than five (5) business days of any systems or operational issues that may impact disbursements by the prescribed time lines.

   The file described in i. above, must contain all transactions that make up the payments in the file described in number ii. above.

b. The State reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The State also reserves the right to withhold amounts owed to the State by any provider for which the Contractor submits a payment request. The Contractor is encouraged to offer automatic deposit to its providers. The Contractor is responsible for providing remittance advices to providers unless the provider elects not to receive hardcopy RA's. Remittance advices shall be included in payments by the Contractor to providers. The Contractor is responsible for ensuring that any payments requested are accurate and in compliance with the terms of this contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.

c. The Contractor shall have in place, a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable TennCare policies and procedures and the terms of this Agreement. The Contractor shall mail checks and remittance advices to pharmacy providers on Friday of each week for all claims submitted through the POS online pharmacy claims processing system and for all batch and paper claims. The Contractor shall pay within twenty (20) calendar days of receipt ninety- five percent (95%) of all clean claims submitted by network and non-network pharmacy providers through POS, batch electronic and paper claims submission. The term "pay" means that the Contractor shall

either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. Thereafter, the Contractor shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The Contractor must pay the claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) a claim that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. These manuals shall provide instructions to providers in the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments.

d. The Contractor shall be responsible for processing all TennCare pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims shall be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, suspend, or deny. The pharmacy can initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function must be available for claims submissions by pharmacies 24 hours a day, 7 days a week (except for regularly scheduled and separately approved downtimes). TennCare providers are responsible for purchasing POS hardware, software and all telecommunications linkages. POS shall be required of all pharmacy providers. Long term care pharmacy providers and the Tennessee Department of Health may submit batch claims as described herein.

e. The Contractor must have a procedure to, on a daily basis, maintain and update enrollee profiles with information including, but not limited to, eligibility, prescriptions submitted for adjudication to TennCare, other prescriptions, over-the-counter medications, diagnosis codes, etc. As a part of TennCare reform efforts, TennCare intends to eliminate OTC drug coverage for all adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. Upon notification by TennCare that these provisions of the reform effort have gone into effect and communication from TennCare to the Contractor concerning the identification of eligible enrollees utilizing the standard HIPAA 834 transaction as defined in the TennCare Companion Guide, the Contractor must have appropriate processes in place to assure that OTC drugs are only reimbursed under the circumstances described above.

4. Amend Section A.2.2.2.b by deleting the entire section and substituting with the following:

b. The Contractor must establish a mail room that shall receive paper and batch electronic claims. The Contractor shall microfilm or otherwise image all payment requests, payments, and their related documents, adjustments, voids, prior authorizations and other documents. The microfilm/image shall be the permanent record of the claim.

The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong

address and/or if the enrollee is communicating information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly, in a yet to be determined mutually agreed upon format, to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.

Failure to report monthly to the Bureau or to open and appropriately manage returned mail may result in liquidated damages as provided in Attachment A.

5. **Amend Section A.2.2.2.e by deleting the entire section and substituting with the following:**

e. The Contractor will assist TennCare in generating Medicaid quarterly drug rebate invoices by providing the designated TennCare staff monthly encounter data files that contain the specific information and in the specified format. These monthly encounter data files will be provided to TennCare no later than the fifteenth (15^{th}) day of each month.

6. **Amend Section A.2.2.2.f by deleting the entire section and substituting with the following:**

f. The Contractor must provide to the agency or business of the state's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data will be provided within fifteen (15) business days of the request by TennCare.

7. **Amend Section A.2.2.2.h by deleting the entire section and substituting with the following:**

h. The Contractor will provide TennCare with TennCare-POS statistics of transactions between the "switches" and the Contractor related to any and all downtime associated with the Contractor's pharmacy claims processing system. Contractor must report to TennCare immediately (within two hours) upon knowledge of unscheduled or unapproved downtime. Transaction reports will include: volume, longest response time and average response time. Statistics will be provided to TennCare within ten (10) business days following the end of each calendar month.

The Contractor shall issue a report to TennCare within two (2) hours upon knowledge of downtime. Transaction reports are due ten (10) business days after end on month of reporting period. Failure to report as provided herein may result in liquidated damages as provided in Attachment A.

8. **Amend the Contract by adding the Section A.2.2.2.i which will read as follows:**

i. The Contractor shall ensure that collection letters are sent to contracting pharmacies which maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old. Mailing and printing costs for these letters shall be a reimburseable pass-through from TennCare.

Failure to send the notices as scheduled may result in liquidated damages as provided in Attachment A.

9. Amend the Contract by adding the Section A.2.2.2.j which will read as follows:

j. The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date.

The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. This notice shall remind the labeler that interest will be assessed on all past due accounts as stipulated by their contract with the State.

Failure to send the notices as scheduled may result in liquidated damages as provided in Attachment A.

10. Amend the Contract by adding the Section A.2.2.2.k which will read as follows:

k. The Contractor shall ensure that all Drug Manufacturers are invoiced for interest as stipulated in each Manufacturer's respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise. Contractor shall provide TennCare with a monthly report of remitted checks as stipulated.

Failure to charge interest as scheduled may result in liquidated damages as provided in Attachment A.

11. Amend the Contract by adding the Section A.2.2.2.l which will read as follows:

l. The Contractor shall provide TennCare Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State which remain outstanding (which have not been cashed) greater than ninety (90) days.

Failure to report to TennCare as scheduled may result in liquidated damages as provided in Attachment A.

12. Amend Section A.2.2.3.h by deleting the entire section and substituting with the following:

h. Recipient Validation - The system must approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. TennCare shall be responsible for assuring that the eligibility file provided is accurate and complete. The Contractor must use this information to immediately (within two (2) business days) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. If

the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for TennCare, then the Contractor is required to recoup monies paid to any provider and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. The Contractor shall report monthly the amount recouped by the Contractor and the amount to be repaid to TennCare. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services.

Failure to report monthly and/or reimburse TennCare monthly may result in liquidated damages as provided in Attachment A.

13. Amend Section A.2.2.3 by adding the following sections:

p. Phase I shall include the following edits:

Script Limit Edit
This claim limit restricts the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit. A "hard" limit restricts dispensing to the specified limit with the exception of drugs included on a shortlist developed by TennCare. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction, as defined by the TennCare Companion Guide. The Contractor must use this information to immediately (no more than two (2) business days) identify those enrollees who have no limits, have no pharmacy benefit, or are subject to limits, and make necessary systems changes to process claims accordingly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.

Tiered Co-pay Edit
A tiered co-pay structure shall be coded into the POS system. Initially, only two tiers may be established. A more complex structure may be required by TennCare at a later date without any additional implementation or pre-operational compensation due to the Contractor.

Step Therapy
PDL management identifies and promotes the use of the most cost-effective drug therapy within a therapeutic class; step therapy promotes the use of the most cost-effective therapy for a specific indication, regardless of drug class. The POS system shall be coded to edit on all drugs in the target classes which are being submitted for dispensing. There shall need to be evidence in the claims history of prior use of a drug in a more cost-effective class before the new drug can gain approval through a prior authorization. Also included in this enhancement is the establishment of prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. To the extent these criteria are not associated with drugs in categories reviewed for the PDL, the call center rates specified in Attachment B shall apply. The Contractor shall assure that call center staff shall be available to evaluate prior authorization requests per the standards required in section A.3.5.1 and A.3.5.3 of the contract. An agreed upon set of edits/PA criteria in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due

to the Contractor. While the Contractor shall recommend possible step therapy edits or Prior Authorization criteria for review by the Pharmacy Advisory Committee, the State shall have final decision on method and timing of implementation.

Gross Amount Due (GAD) Edit
As defined by TennCare.

Drug to Gender Edit
Any medication which is specifically indicated for either a male or female shall reject at the point of service if the medication is prescribed for a patient of the opposite gender.

Maximum Dollar Amount Edit
All pharmacy claims over a specified dollar amount per claim shall reject at the point of service and shall require the pharmacy provider to call the First Health Services Call Center. This includes a $250 limit on compounded claims, a $10,000 limit on non-compounded, non-exception claims, a $2,500 limit on Total Parenteral Nutrition (TPN) products and a $50,000 limit on exception claims (blood factors and other identified products).

DEA Number Edit
The claims processing system shall be set to deny for all controlled substances where the DEA number used is not active in the National DEA file (NTIS) used by the Contractor.

Drug Dosage and Dose Optimization Edit
The dose optimization edit shall assess the tablet strengths of a drug and assure that the most cost-effective strength is dispensed. Appropriate selection shall assist in minimizing the cost of therapy. The POS system shall be coded to limit the quantity per prescription to ensure the most cost-effective strength is dispensed. Also, where there are appropriate concerns with respect to over-utilization of medications, quantity limits shall be entered into the system. The pharmacy shall receive a hard denial for any claim that exceeds the limit. A prescriber must obtain a prior authorization in order for the claim to process through the system.

An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor.

Drug Duplication of Therapy Edit
This edit automatically identifies and reports problems that involve therapeutic duplications of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee.

OTC Drug Coverage Elimination
TennCare intends to eliminate OTC drug coverage for all adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions.

q. Phase II shall include the following edits:

Unit of Measure Edit

The Unit of Measure (UOM) edit shall perform two main functions:

a) check incoming claim units (i.e. gram, ml, etc) versus the units listed in First Databank for that particular NDC

b) verify that the unit amounts transmitted are consistent with the unit amounts in First Databank (The submitted quantity must be a multiple of the unit size shown in FirstDatabank. i.e. claim shall be rejected if unit amount transmitted has been rounded, - example - units transmitted is 14, but unit amount is 13.7 in First Databank)

MAC/DAW
This edit requires medical justification to be provided for a Branded product when a generic substitute is available. When a prescriber writes a prescription for a multi-source product and requests that the prescription be Dispensed As Written (DAW), the pharmacist uses the DAW edit to allow dispensing of the brand, but the claim shall only pay at the lower payment (MAC). The pharmacist shall call the prescriber and change the prescription to an alternate agent. If the prescriber will not change to an alternate agent, then the prescriber or prescriber's agent must call for a prior authorization.

Definition of MAC
The pricing of claims is driven by the pricing methodologies described by TennCare rules and policies. The system must compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current TennCare pricing methodology. Most generic drugs and multisource products shall be assigned Maximum Allowable Cost (MAC) prices by the federal government or by TennCare. The Contractor's system must allow for such MAC price changes, as well as any other price adjustments, to be made online, real time by the TennCare Pharmacy Director or his/her appropriate staff on the day requested. NCPDP overrides at the POS level must be available to the dispensing pharmacist in the event a DAW (dispense as written) override is necessary and allowed or required by TennCare policy.

As of January 1, 2005, TennCare's claim pricing is based on the MAC pricing provided by the Contractor. During Phase II implementation, the Contractor shall change certain MACs at the direction of TennCare, provided that the Contractor can confirm that the drugs can be acquired for such prices. The Contractor shall be responsible for ongoing MAC pricing maintenance and provider appeals related to those changes. Subsequent changes may be implemented upon the direction of TennCare after completion of Phase II implementation without additional implementation or pre-operational compensation due the Contractor, provided the total number of drugs involved in such changes does not exceed one hundred (100) drugs (drug equals Generic Sequence Number or GSN).

r. Phase III shall include the following edits:

Prescriber Last Name Edit
The claims processing system shall be set to ensure that the submitted prescriber last name correctly matches the last name associated with the submitted DEA number that is present on the National DEA file (NTIS) used by the Contractor.

Drug Duration Edit

Duration of Therapy is performed to determine whether the current prescription exceeds the recommended maximum days supply for that drug and is based on commonly used drug and clinical data.

Drug to Disease Edit
This edit automatically identifies and reports problems which involve use of drugs contraindicated by inferred diagnosis codes on current and historical claims for a given enrollee.

Drug-Drug Interaction Edit
This edit automatically identifies and reports problems that involve use of drugs contraindicated by other drugs on current and historical claims for a given enrollee. Also, it automatically indicates and reports on the level of severity of the drug/drug interaction.

Throughout implementation of all phases, the Contractor shall review children's prescriptions at POS to screen for possible fraudulent attempts by adult recipients to obtain prescriptions for themselves. The Contractor and TennCare staff shall agree upon criteria to produce a retrospective report containing such findings with recommendations for prevention of such practices.

The Contractor guarantees that the implementation of the above named initiatives will result in cost savings for TennCare equal to or greater than the implementation and monthly administration fees associated with these initiatives. Contemporaneous with the implementation of the various savings initiatives, the parties shall negotiate and mutually agree upon the necessary assumptions, the formula for calculating the baseline and resultant savings, and any incentive to which the contractor may be entitled for exceeding the agreed upon savings.

Failure to meet deadlines in Phase I, Phase II or Phase III or to perform as required by the Contract shall result in liquidated damages as set out in Attachment A of the Contract.

14. **Amend Section A.2.2.4.b by deleting the entire section and substituting with the following:**

b. The pricing of claims is driven by the pricing methodologies described by TennCare rules and policies. The system must compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current TennCare pricing methodology. Most generic drugs and multisource products shall be assigned Maximum Allowable Cost (MAC) prices by the federal government or by TennCare. The Contractor's system must allow for such MAC price changes, as well as any other price adjustments, to be made online, real time by the TennCare Pharmacy Director or his/her appropriate staff on the day requested. NCPDP overrides at the POS level must be available to the dispensing pharmacist in the event a DAW (dispense as written) override is necessary and allowed or required by TennCare policy.

As of January 1, 2005, TennCare's claim pricing is based on the MAC pricing provided by the Contractor. During Phase II implementation, the Contractor shall change certain MACs at the direction of TennCare, provided that the Contractor can confirm that the drugs can be acquired for such prices. The Contractor shall be responsible for ongoing MAC pricing maintenance and provider appeals related to those changes. Subsequent changes may be implemented upon the direction of TennCare after completion of Phase II implementation without

additional implementation or pre-operational compensation due the Contractor, provided the total number of drugs involved in such changes does not exceed one hundred (100) drugs (drug equals GSN).

15. **Delete Section A.2.2.4.f in its entirety.**

16. **Amend Section A.2.2.6 by deleting the entire section and substituting with the following:**

Reversals and Adjustments. The system must provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. The result of the adjustment must be transferred to TCMIS for further processing. TennCare will make no payments to the Contractor for reversed, voided or adjusted claims. Contractor shall process all reversals requested by TennCare fiscal within 30 days and provide confirmation to TennCare fiscal that such has occurred.

Failure to reverse or adjust claims within 30 days may result in liquidated as provided in Attachment A.

17. **Amend Section A.2.4.2 by deleting the entire section and substituting with the following:**

A.2.4.2. Encounter Reports. Post-adjudicated claims (encounters) must be reported by the Contractor on a schedule designated by TennCare. The current schedule is weekly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.

Failure to report post-adjudicated claims (encounters) to TennCare weekly as directed by TennCare may result in liquidated damages as provided in Attachment A.

18. **Amend Section A.3.1.10 by deleting the entire section and substituting with the following:**

The Contractor will support the management and coordination of all activities related to the maintenance of the TennCare PDL. Activities will include but not be limited to the following:

- The Contractor will present the TennCare Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the TennCare PDL.
- The Contractor will present the TennCare Pharmacy Advisory Committee clinical review of existing drugs for new indications or changes to indications that might affect their inclusion in the TennCare PDL.
- The Contractor will annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to TennCare regarding supplemental rebate strategies.
- The Contractor will develop changes to drug review criteria for the TennCare PDL based on new clinical and pharmacoeconomic information.
- The Contractor will analyze cost information relative to drug alternatives as they affect the TennCare PDL.

Purpose and Scope of Reviews

- The primary function of the PDL drug class review is to assist the Committee members in determining if the drugs within the therapeutic class of interest can be considered therapeutic alternatives.

- PDL decisions are limited to *within* class comparisons—unlike a hospital or MCO formulary drug review (which is usually drug-specific and not class-specific), PDL drug class reviews usually have limited data concerning the drug class's place in therapy or comparisons to other drugs outside the drug class in question.

- These reviews not designed to be used for other purposes such as development of DUR criteria, prospective edits, step therapy edits, etc.

Disclaimer Printed on Drug Class Review

- The clinical information contained herein is provided for the express purpose of aiding the Pharmacy and Therapeutics ("P&T") Committee members in reviewing medications for inclusion in or exclusion from the Preferred Drug List.

- This information is not intended nor should it be used as a substitute for the expertise, skill, and judgment of physicians, pharmacists, or other healthcare professionals.

- The absence of a warning for any given drug or drug combination should not be construed to indicate that the drug or drug combination is safe, appropriate or effective for any given patient.

- This information is intended to supplement the knowledge and additional resources available to the P&T Committee members and should not be considered the sole criteria used by the P&T Committee in deciding what medications will be included or excluded from the Preferred Drug List.

- The Contractor will monitor compliance by prescribers and pharmacists with the TennCare PDL, report that information to TennCare monthly and quarterly, and semiannually, and provide suggestions for improving PDL compliance.

The Contractor shall create and forward a PDL Bonus Payment Report which shall outline the percentage of prescriptions dispensed which have adhered to the PDL during the previous six (6) month period. This Report shall be sent directly to TennCare Fiscal Services Unit within forty-five (45) days following the period but not earlier than thirty (30) days following the period.

Failure to provide this report as directed by TennCare may result in liquidated damages as provided in Attachment A.

19. Amend Section A.3.1.11 by deleting it in its entirety and substituting the following:

A.3.1.11.The Contractor will attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee as necessary to maintain the TennCare PDL. Such support will include responsibility to taking minutes at all Pharmacy Advisory Committee meetings.

20. Amend Section A.3.3.1 by deleting it in its entirety and substituting the following:

A.3.3.1. The Contractor shall develop and implement an effective education program for providers (prescribers and pharmacists) that explains how the TennCare PDL and prior authorization programs operate. The education program initiative must begin prior to the effective date of the TennCare PDL and prior authorization programs and continue on an ongoing basis. On an ongoing basis this education program will include interventions with providers and pharmacists to improve compliance with the PDL.

21. Amend Section A.3.8. (f) by deleting it in its entirety and substituting the following:

f. Quarterly reports demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the outcomes of those interventions.

22. Amend Section A.3.6 by deleting the entire section and substituting with the following:

A.3.6 Staff Dedicated to TennCare

Pharmacy Clinical Manager
The Contractor shall provide a Pharmacy Clinical Manager to offer clinical program support to TennCare. The Clinical Manager assigned to this project must be a licensed pharmacist with a Doctor of Pharmacy degree from an accredited pharmacy school and approved by TennCare. If it becomes necessary for the Contractor to replace the Clinical Manager, the Contractor shall notify TennCare within three (3) business days of the change.

Pharmacy Contract Project Director and Staff
The Contractor shall designate and maintain, subject to TennCare approval, a Project Director for this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours by working onsite within the TennCare Bureau. The Contractor's staff addressed herein shall be available to attend meetings as requested by TennCare. TennCare shall provide office space for the Contractor's onsite Pharmacy Project Director. The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis including but not limited to the following personnel, all of whom must be dedicated 100% to TennCare:

a. one (1) clinical pharmacist located in Nashville,
b. two (2) provider educator pharmacists located in Nashville,
c. one (1) pharmacy research scientist located in Nashville,
d. one (1) data quality analyst located in Nashville,
e. one (1) system liaison located in Richmond and available in Nashville upon request from TennCare,
f. one (1) contract manager located in Richmond,
g. one (1) business analyst located in Richmond,
h. one (1) project manager to address program changes based 25% in Nashville and 75% in Richmond.

i. two (2) mail room clerks located in Richmond.

Telephone and administrative personnel shall be familiar with covered services under the TennCare pharmacy program and other member eligibility prerequisites. TennCare shall have the right to approve the Project Director and any other key positions. TennCare shall have the right to require removal, in writing, from this Contract of any staff found unacceptable to TennCare with cause. TennCare shall be notified within three (3) business days of key staffing changes and name changes and TennCare shall have the right to approve any such changes. The Project Director shall provide overall project coordination between the clinical and operational aspects in support to TennCare. If it becomes necessary for the Contractor to replace the Project Director, the Contractor shall notify TennCare within three (3) business days of the change and TennCare shall approve any such changes.

23. Amend the Contract by adding Section A.3.9 which will read as follows:

The Contractor shall have the technical capability to remove drugs from the PDL as requested by TennCare.

Failure to remove drugs from the PDL within the time as specified by TennCare will result in penalties assess equal to the cost of said drug from the date established by TennCare and the date implemented.

24. Amend Section A.11 by deleting the entire section and substituting with the following:

A.11. TennCare Member Identification Cards

The Contractor shall provide each TennCare member with a permanent pharmacy benefit identification card by February 1, 2004. The card shall comply with all state laws and NCPDP guidelines regarding the information required on the card. The card shall also list any appropriate copays for the member, an effective date for the card, and any other information required by TennCare. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file and members whose benefit limits have changed on an ongoing basis. The cards shall be produced and mailed by the Contractor on the 15th day of each month. To the extent that the reissue of TennCare Member Identification Cards is necessary to implement pharmacy reform (including prescription limits and tiered co-pays), the Contractor must assure that all enrollees receive their new ID cards at least fifteen (15) days prior to the planned implementation date.

The Contractor shall be reimbursed for costs as acceptable and approved by TennCare and which relate to the production or replacement of the identification cards. The Contractor must invoice TennCare in writing and must delineate the actual costs incurred. TennCare has the final approval on payment of the invoice.

Mailings pursuant to this Section of the Contract shall be mailed first class unless otherwise approved or directed by the State. The direct postage cost shall be a pass-through item and shall not include Contractor postage for Contractor business operations. The State shall reimburse the Contractor for actual costs.

The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating information to the Contractor or to TennCare. The

Contractor shall track returned mail and shall report monthly to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.

Failure to report monthly to the Bureau or to open and appropriately manage returned mail may result in liquidated damages as provided in Attachment A.

25. Amend Section A.14 of the Contract by deleting it in its entirety and substituting the following:

A.14. The Emergency Supply Override

The Contractor shall assure that the TennCare-POS system allows pharmacists to execute an emergency or "*Grier* Override" that shall process an emergency supply of drugs in normally covered therapeutic categories that are not listed on the TennCare PDL. The Contractor's TennCare-POS system must post a message for the dispensing pharmacist to contact the prescriber, so that the pharmacist can suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency or *Grier* Override must be in a therapeutic class normally covered by TennCare. The Contractor shall instruct pharmacy providers how to perform the *Grier* Override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system.

If TennCare determines that modification of the Grier override system is necessary to comply with changes in the consent decree or to control pharmacy costs in a manner consistent with the current consent decree, the Contractor shall make such modifications as directed by TennCare. A requirements session will be conducted to identify the required logic, a business plan shall be developed, and the changes shall be implemented after sufficient time has been allotted for coding and testing of all changes. Such coding changes shall be compensated at the System Change Request hourly rate.

Failure by the Contractor to allow the POS emergency or *Grier* Override for all appropriate, emergency claims may result in the assessment of liquidated damages by TennCare of two hundred dollars ($200) per day during the first month violations are identified. Liquidated damages will increase to four hundred dollars ($400) per day for the second consecutive month violations are identified. TennCare will monitor emergency or *Grier* Overrides and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

26. Amend Section C.1 by deleting the entire section and substituting with the following:

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty-Seven Million Nine Hundred Thousand Dollars ($37,900,000.00) *The* Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment

required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor. Notwithstanding the above, the Contractor shall be reimbursed for any "pass-through" costs for which the parties have agreed.

In the event the maximum liability is to be exceeded because of unanticipated volumes of activity payable on a per unit basis hereunder, then Contractor shall promptly notify TennCare in writing so that TennCare can adjust the amount of this maximum liability provision. Contractor shall have no obligation to continue to provide services at any time the maximum liability, as adjusted, has been exceeded.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

27. **Amend Section C.3 by deleting the entire section and substituting with the following:**

C.3. Payment Methodology. The Contractor shall be compensated based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following Service Rates:

Monthly Fee Year 1 $484,500.00
Monthly Fee Year 2 $346,750.00
Monthly Fee Year 3 $351,500.00
Monthly Fee Year 4 (if renewed by amendment) $356,250.00
Monthly Fee Year 5 (if renewed by amendment) $361,000.00

In addition to the monthly fee, TennCare will compensate the Contractor as provided herein in accordance with specified rates in Attachment B and Attachment C. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall at a minimum, include:

the numbers and types of pharmacy claims adjudicated; separately itemized actual payments made to pharmacy service providers for each pharmacy claim adjudicated; subtotal for all pharmacy claims adjudicated; subtotal of all actual payments; the comprehensive monthly fee in effect, and the total amount due to the Contractor for the period invoiced.

28. Amend Section E.4 by deleting the entire section and substituting with the following:

E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

- failure to perform in accordance with any term or provision of the Contract;
- partial performance of any term or provision of the Contract;
- any act prohibited or restricted by the Contract; or
- violation of any warranty.

For purposes of this Contract, and any amendments entered herein, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the state shall have available the remedy of Actual Damages or assessed penalties up to the maximum limits provided herein and, in addition, any nonmonetary remedy available at law or equity.

(2) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall begin to provide the service associated with the Breach. In the event of a Partial Default, the parties shall negotiate the appropriate compensation payable to Contractor. In the absence of agreement on compensation for such reduced services, either party may terminate the contract for convenience upon thirty (30) days notice.

Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material in its then existing format from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with

said Liquidated Damages to cease when said Partial Default is effective (see Attachment A). Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken. The amount of these liquidated damages assessed against the Contractor shall be in accordance with the specific penalty provisions contained herein but shall not exceed ten per cent of the amount previously paid by TennCare to Contractor for services provided under the Contract.

(3) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately.. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any an all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notices shall operate as an absolute waiver by the Contractor of the State's breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure within thirty (30) days of receipt of the breach notice as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

29. Amend the Contract by adding a new section E.20 which will read as follows:

State Interest in Equipment – Uniform Commercial Code Security Agreement

The Contractor shall take legal title to all equipment purchased totally or in part with funds provided under this Amendment, subject to the State's equitable interest therein, to the extent of its *pro rata* share, based upon TennCare's contribution to the purchase price. "Equipment" shall be defined as an article of nonexpendable, tangible, personal property which (i) has a useful life of more than one year, (ii) has an acquisition cost which equals or exceeds five thousand dollars ($5,000.00) and (iii) is used exclusively in the performance of this Contract.

As authorized by the provisions of the terms of the Tennessee Uniform Commercial Code – Secured Transaction, found at Title 47, Chapter 9 of the ***Tennessee Code Annotated***, an intent of this Amendment and the parties hereto is to create and acknowledge a security interest in favor of TennCare in the Equipment acquired by the Contractor pursuant to the provisions of this Amendment.

The Contractor hereto grants TennCare a security interest in said Equipment. This agreement is intended to be a security agreement pursuant to the Uniform Commercial Code (UCC) for any Equipment herein specified which, under applicable law, may be subject to a security interest pursuant to the UCC, and the Contractor hereby grants TennCare a security interest in said equipment. The Contractor agrees that TennCare may file this Amendment, or a reproduction thereof, in any appropriate office, as a financing statement for any of the equipment herein specified. Any reproduction of this or any other security agreement or financing statement shall be sufficient as a financing statement. In addition, the Contractor agrees to execute and deliver to TennCare, upon the request of TennCare, any financing statements, as well as extensions, renewals, and amendments thereof, and reproduction of this Amendment in such form as TennCare may require to perfect a security interest with respect to said Equipment. The Contractor shall pay all costs of filing such financial statements and any extensions, renewals, amendments and releases thereof. Without prior written consent of TennCare, the Contractor shall not create or suffer to be created pursuant to the UCC, any other security interest in said Equipment, including replacements and additions thereto. Upon the Contractor's breach of any covenant or agreement contained in this Amendment, TennCare shall have the remedies of a secured party under the UCC and, at TennCare's option, may also invoke remedies herein provided.

The Contractor agrees to be responsible for the accountability, maintenance, management, and inventory of all property purchased totally or in part with funds provided under this Amendment. The Contractor shall maintain a perpetual inventory system for all Equipment purchased with funds provided under this Amendment and shall submit and inventory control report which must include, at a minimum, the following:

a. Description of the Equipment;
b. Manufacturer's serial number or other identification number, when applicable;
c. Consecutive inventory Equipment tag identification;
d. Acquisition date, cost, and check number;
e. Percentage of State funds applied to this purchase;
f. Location within the Contractor's operations where the Equipment is used;
g. Condition of the property or disposition date if Contractor no longer has possession;
h. Depreciation method, if applicable; and
i. Monthly depreciation amount, if applicable.

The Contractor shall notify TennCare, in writing, of any Equipment loss describing reason(s) for the loss. Should the Equipment be destroyed, lost, or stolen, the Contractor shall be responsible to TennCare for the *pro rata* amount of the residual value at the time of loss based upon TennCare's original contribution to the purchase price, unless Contractor chooses to replace the Equipment at its own cost to continue performance under the Contract.

Upon termination of the Contract, where a further contractual relationship is not entered into, or at another time during the term of the Contract, the Contractor shall request written approval from TennCare for any proposed disposition of Equipment purchased pursuant to this Amendment. All Equipment shall be disposed of in such manner as

parties may agree from among alternatives approved by Tennessee Department of General Services and in accordance with any applicable federal laws or regulations.

30. **Amend the Contract by adding Section E. 21 which will read as follows:**

Performance Reviews. Contractor shall cooperate with any performance review conducted by TennCare, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the Contract or its Amendments. Upon reasonable notice, TennCare may conduct a performance review and audit of Contractor to determine compliance with the Contract and its Amendments. At any time, if TennCare identifies a deficiency in performance, liquidated damages as specified herein may be assessed, and the Contractor will be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how TennCare members will continue to be served until the deficiency is corrected.

TennCare reserves the right to conduct on-site audits and reviews with reasonable notification to the Contractor.

31. **Delete Attachment A in its entirety and replace with revised Attachment A.**

32. **Add Attachments B and C.**

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President
Date

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner
Date

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner
Date

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury
Date

ATTACHMENT A

LIQUIDATED DAMAGES FOR PERFORMANCE MEASURES

PERFORMANCE MEASURE	REPORTING REQUIREMENT	DELIVERABLE	PENALTY
A.1.1 Program Enhancements	Within thirty (30) days of signature of this Amendment, the Contractor shall develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each program enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.	Within thirty (30) days of signature of Amendment, report format is due for TennCare review. Reports due monthly, ten (10) business days after end of month of reporting period, beginning for the first full month after the report format has been agreed to FirstIQ reports are due monthly, fifteen (15) days after the end of the monthly reporting period.	Damages will be assessed weekly. Calculation of the damages will begin on the first day following the report due date and will continue until receipt of the report by TennCare. Penalty will be $2,500 per week.
A.2.2.1 Claim Adjudication Services – General Requirements	The Contractor shall distribute and mail TennCare outputs as required by the contract including, but not limited to, provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of Holiday weeks. TennCare shall be notified no later than five (5) business days of any systems or operational issues that may impact disbursements by the prescribed timelines. a. Cash flow – For checks to be issued on Friday, the Contractor must deliver two files to the State, in an electronic media suitable to the		a. Cash flow – Penalty will be $1,000 per day files are overdue.

	State, by 10:00 a.m. Thursday of each week.		
A.2.2.2.b Mail Procedures	The Contractor shall open all returned mail from any mailings to enrollees or providers within 30 days of receipt to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.	Monthly report, due ten (10) business days after end of month of reporting period , beginning for the first full month after the report format has been agreed to .	Calculation of the damages will begin on the first day following the report due date and will continue until receipt of the report by TennCare. Penalty will be $2,500 per week.
A.2.2.2.e. Assistance in Generating Quarterly Drug Rebate Invoices	The Contractor shall provide designated TennCare staff quarterly encounter data files that contain the specific information and in the specified format required by TennCare to deliver the Medicaid quarterly drug rebate invoices. These quarterly encounter data files shall be provided to TennCare no later than the fifteenth (15th) day after the end of quarter. Any changes to supporting data must be provided to FirstHealth no later than 45 days prior to the end of the quarter. This includes but is not limited to Unit of Measure updates, Supplemental NDC's that should not be included in the FirstRebate extract, and valid provider list.	Quarterly files, due fifteen (15) business days after end of the quarter for reporting period.	Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare. Penalty will be $5,000 per week.
A.2.2.2.f. Drug Rebate Dispute Data	The Contractor must provide to the agency or business of the state's choosing, in its then	This data must be provided to TennCare within fifteen (15) days of a request by	Calculation of the damages will begin on the first day

	existing format, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data will be provided within fifteen (15) business days upon TennCare's sign off of the final Change Control memo. If the request can not be fulfilled within 15 business days, the Contractor shall notify TennCare in writing of the delay, and a mutually agreed upon date will be determined..	TennCare	following the due date and will continue until receipt of the report by TennCare. Penalty will be $5,000 per week.
A.2.2.2.g.i. Batch Electronic Media (EMC) Claims Processing	The Contractor must receive claims in electronic format, separate tape from diskette, convert diskette to tape, schedule tapes for immediate processing and return media to submitting providers within three (3) business days. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The Contractor shall maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these must be provided within three (3) business days of request. As requested, the Contractor will provide the batch files as they were originally received. These files will be delivered to the TennCare site via VPN. Electronic batch claims shall be submitted through a sequential terminal, or similar method that shall allow batch and POS claims to be adjudicated through the same processing logic. New providers requesting	Return media claims to submitting providers within three (3) business days of receipt, assignment of identification control numbers to all batch claims within three (3) business days of receipt and provide TennCare with copies of batch electronic claims within three (3) business days of request.	Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare. Penalty will be $1,000 per day.

	to submit batch claims must provide at least a 30 day notice and must conform to the standard Change Control and testing process.		
A.2.2.2.g.ii. POS Claims	The Contractor shall process POS pharmacy claims within five (5) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication.	Five (5) seconds per processed pharmacy claim through the Contractor's POS system	If 95.5 percent of claims are not processed within the 5 second time frame then the daily penalty will be $1,000 per day of non-compliant processing.
A.2.2.2.g.iii. Paper Claims	Paper claims may include, but not be limited to, those submitted in situations when an enrollee has to visit an out-of-state pharmacy in an emergency or paper claims from any of the Tennessee Department of Health clinics. Paper claims shall be submitted on universal claim forms. The Contractor shall process and adjudicate these universal, paper claims within twenty (20) days of receipt. The Contractor shall add all pertinent drug information data to the TennCare-POS system and DUR system immediately upon processing the claim.	Paper claims must be processed within twenty (20) days of receipt.	Penalty will be $100 per day per claim in excess of the twenty (20) day processing requirement.
A.2.2.2.h. POS Downtime Notification	Contractor must report to TennCare immediately (within two (2) hours) upon knowledge of downtime. For purposes hereof "downtime" shall be any continuous one-hour period of time in which the system is not operational. TennCare is to identify staff to be contacted after normal business hours in the event of an interruption of service.	Report due immediately, within two (2) hours, upon knowledge of downtime.	Immediate report due within two (2) hours upon knowledge of the downtime. $7,500 one time damage for not reporting immediately.

A.2.2.2.h. POS Downtime Statistics	The Contractor shall provide TennCare with TennCare-POS statistics of transactions between the "switches" and the Contractor related to any and all downtime associated with the Contractor's pharmacy claims processing system. Transaction reports shall include: volume, longest response time and average response time. Statistics shall be provided to TennCare within ten (10) business days following the end of each calendar month in which any downtime occurred.	Report due ten (10) business days after end of month of reporting period in which any downtime occurred.	Daily penalty will be $1,000 per day. Calculation of the damages will begin on the first day following the due date of the report and will continue until receipt of the report by TennCare.
A.2.2.2.i	The Contractor shall ensure that collection letters are sent to pharmacies which maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old.	Contractor shall provide TennCare with a monthly report of notices that had been sent. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty will be $100 per provider notice per month.
A.2.2.2.j	The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. This notice shall remind the labeler that interest will be assessed on all past due accounts as stipulated by their contract with the State.	Contractor shall provide TennCare with copies of all reports sent pursuant to this section. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty will be $100 per Manufacturer per day independent of other dunning periods.
A.2.2.2.k	The Contractor shall ensure that all Drug Manufacturers are charged interest as stipulated in each Manufacturer's		Failure by Contractor to start accruing interest on the date stipulated

	respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise.		in the individual supplemental rebate agreements will result in a penalty of $1,000 for every non-compliant invoice issued.
A.2.2.2.l	The Contractor shall provide TennCare Fiscal Services Unit a monthly report detailing all checks remitted to providers on behalf of the State which remain outstanding (have not been cashed) greater than ninety (90) days.	Contractor shall provide TennCare with a monthly report of remitted checks as stipulated. Reports due monthly, due on the 15th day of the month following the reporting period.	Penalty will be $500 per week that report is overdue.
A.2.2.3.h Recipient Validation	The system must approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. The Contractor must use this information to immediately (within two (2) business days) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. If the Contractor bills for any claims for a recipient who is deceased at the time the service was allegedly provided or who is no longer eligible for TennCare and the Contractor should have been aware of such at the time the claim was paid (i.e. the change in eligibility had been communicated to the	Monthly report due ten (10) business days following the end of the calendar month.	$1,000 for each claim processed three (3) business days after written or electronic notification by TennCare of recipient's death or date of ineligibility. $1,000 for each month recoupment is not made on an individual who is known to be deceased or ineligible. $500 for each week report is late. Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare.

	Contractor by TennCare via the HIPAA 834 prior to the processing of the claim), then the Contractor is required to recoup monies paid to any provider and repay TennCare for the claims post date of death or post eligibility for enrollment. If the Contractor bills for any claims for a recipient who is deceased at the time the service was allegedly provided or who is no longer eligible for TennCare and the Contractor could not have been aware of such at the time the claim was paid (i.e. the Contractor is notified of a retroactive termination), then the Contractor shall make every effort reasonable effort to recoup monies paid to any provider and will repay TennCare in the amount collected. The Contractor shall report monthly the amount recouped by the Contractor and the amount to be repaid to TennCare. The Contractor shall submit a draft report format for TennCare review within thirty (30) days of signature of this Amendment Two. The report format will be agreed upon by the Contractor and TennCare a minimum of thirty (30) days prior to the delivery of the initial report. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services. This will be done upon the reversal of identified claims. TennCare is responsible for		

	communicating termination dates, in addition to the date of death, for any deceased members using the standard 834 transaction.		
A.2.2.3 Phases I, II, and III – Implementation dates	Phase I shall include the following edits: <u>Script Limit Edit</u> This claim limit restricts the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit. A "hard" limit restricts dispensing to the specified limit with the exception of drugs included on a shortlist developed by TennCare. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. The Contractor must use this information to immediately identify individuals who have no limits, have no pharmacy benefit, or are subject to limits. or whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. <u>Tiered Co-pay Edit</u> A tiered co-pay structure shall be coded into the POS system. Initially, only two tiers may be established. A more complex structure may be required by TennCare at a later date without any additional implementation or pre-operational compensation due to the Contractor.	Phase I shall begin upon signature of Contract Amendment Two. The completion date shall be no later than May 1, 2005	Phase I Implementation: penalty will be $8,000 per week for each edit not operational by May 1, 2005. Calculation to begin on May 2, 2005.

	Step Therapy Edit PDL management identifies and promotes the use of the most cost-effective drug therapy within a therapeutic class; step therapy promotes the use of the most cost-effective therapy for a specific indication, regardless of drug class. The POS system shall be coded to edit on all drugs in the target classes which are being submitted for dispensing. There shall need to be evidence in the claims history of prior use of a drug in a more cost-effective class before the new drug can gain approval through a prior authorization. Also included in this enhancement is the establishment of prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. To the extent these criteria are not associated with drugs in categories reviewed for the PDL, the call center rates specified in Attachment B shall apply. The Contractor shall assure that call center staff shall be available to evaluate prior authorization requests per the standards required in section A.3.5.1 and A.3.5.3 of the contract. An agreed upon set of edits/PA criteria in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the		

	term of the Contract without additional implementation or pre-operational compensation due to the Contractor. While the Contractor shall recommend possible step therapy edits on Prior Authorization criteria for review by the Pharmacy Advisory Committee the State shall have final decision on method and timing of implementation. <u>Gross Amount Due (GAD) Edit</u> As defined by TennCare. <u>Drug to Gender Edit</u> Any medication which is specifically indicated for either a male or female shall reject at the point of service if the medication is prescribed for a patient of the opposite gender. <u>Maximum Dollar Amount Edit</u> All pharmacy claims over a specified dollar amount per claim shall reject at the point of service and shall require the pharmacy provider to call the First Health Services Call Center. This includes a $250 limit on compounded claims, a $10,000 limit on non-compounded, non-exception claims, a $2,500 limit on Total Parenteral Nutrition (TPN) products and a $50,000 limit on exception claims (blood factors and other identified products). <u>DEA Number Edit</u> The claims processing system shall be set to deny for all controlled substances where the DEA number used is not active in the National DEA file (NTIS) used by the Contractor. <u>Drug Dosage and Dose Optimization Edit</u>		

	The dose optimization edit shall assess the tablet strengths of a drug and assure that the most cost-effective strength is dispensed. Appropriate selection shall assist in minimizing the cost of therapy. The POS system shall be coded to limit the quantity per prescription to ensure the most cost-effective strength is dispensed. Also, where there are appropriate concerns with respect to over-utilization of medications, quantity limits shall be entered into the system. The pharmacy shall receive a hard denial for any claim that exceeds the limit. A prescriber must obtain a prior authorization in order for the claim to process through the system. <u>Drug Duplication of Therapy Edit</u> This edit automatically identifies and reports problems that involve therapeutic duplications of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee. An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor. <u>OTC Drug Coverage Elimination</u> TennCare intends to eliminate OTC drug coverage for all		

	adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. Phase II shall include the following edits: <u>Unit of Measure Edit</u> The Unit of Measure (UOM) edit shall perform two main functions: a) check incoming claim units (i.e. gram, ml, etc) versus the units listed in FirstDatabank for that particular NDC b) verify that the unit amounts transmitted are consistent with the unit amounts in First Databank (The submitted quantity must be a multiple of the unit size shown in FirstDatabank. i.e. claim shall be reject if unit amount transmitted has been rounded, - example - units transmitted is 14, but unit amount is 13.7 in FirstDatabank) An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor. <u>MAC/DAW</u> Requires medical justification to be provided for a Branded	Phase II shall begin upon written notification of TennCare. The completion date shall be sixty (60) days following the written notification of TennCare.	Phase II and Phase III Implementation: penalty will $3,500 per week for each edit not operational by "date to complete implementation." Calculation to begin day after "date to complete implementation" (see Section A.1.1).

	product when a generic substitute is available. When a prescriber writes a prescription for a multi-source product and requests that the prescription be Dispensed As Written (DAW). The pharmacist uses the DAW1 edit to allow dispensing of the brand, but the claim shall only pay at the lower payment (MAC) or the pharmacist shall call the prescriber and change the prescription to an alternate agent. If the prescriber shall not change to an alternate agent, then the prescriber or prescriber's agent must call for a prior authorization. Phase III shall include the following edits: <u>Prescriber Last Name Edit</u> The claims processing system shall be set to ensure that the valid DEA number matches the correct last name of the prescriber. <u>Drug-Drug Interaction Edit</u> This edit automatically identifies and reports problems that involve use of drugs contraindicated by other drugs on current and historical claims for a given enrollee. Also, it automatically indicates and reports on the level of severity of the drug/drug interaction. <u>Drug Duration Edit</u> Duration of Therapy is performed to determine whether the current prescription exceeds the recommended maximum days supply for that drug and is based on commonly used drug and clinical data.	Phase III shall begin upon written notification of TennCare. The completion date shall be sixty (60) days following the written notification of TennCare.	

	Drug to Disease Edit This edit automatically identifies and reports problems which involve use of drugs contraindicated by inferred diagnosis codes on current and historical claims for a given enrollee. Many, if not all, of the edits listed above in Phases I to III shall be processed and resolved automatically at POS and require little or no intervention by First Health Services Call Center. It should be understood by the Contractor that lack of resolution of an automated edit shall most likely result in additional calls, leading to an override or prior authorization.		
A.2.2.6	Reversals and Adjustments. The system must provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. The result of the adjustment must be transferred to TCMIS for further processing. TennCare will make no payments to the Contractor for reversed, voided or adjusted claims. Contractor shall process all reversals requested by TennCare Fiscal Services Unit within thirty (30) days and provide confirmation to TennCare Fiscal Services Unit when that such has occurred.		$100 per transaction that has not been reversed or adjusted within thirty (30) days of written request of TennCare Fiscal Services Unit.
A.2.4.2. Encounter Reports	Post-adjudicated claims (encounters) must be reported by the Contractor on a schedule designated by TennCare. The current schedule is weekly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.	Report due weekly and due ten (10) business days after end of reporting week.	If the Contractor fails to produce the report, the calculation of the damages will begin on the first day following the due date of the report and will continue until receipt of the

	Failure to report post-adjudicated claims (encounters) to TennCare weekly may result in liquidated damages as provided herein.		report by TennCare. Penalty will be $5,000 per week.
A.3.1.10	The Contractor will monitor compliance, by prescribers and pharmacists, with the TennCare PDL, report that information to TennCare monthly and quarterly, and semiannually, and provide suggestions for improving PDL compliance. The Contractor shall create and forward a PDL Bonus Payment Report which shall outline the percentage of prescriptions dispensed which have adhered to the PDL during the previous six (6) month period. This Report shall be sent directly to TennCare Fiscal Services Unit within forty-five (45) days following the period but not earlier than thirty (30) days following the period.	Report to be delivered within forty-five (45) days following the period, but not earlier than thirty (30) days following the period.	Penalty will be $500 per week that report is overdue.
A.3.1.17	The Contractor shall perform supplemental rebate calculations including National Drug Code (NDC) information and invoice the manufacturers within five to thirty (5-30) days after the receipt of the quarter CMS rate file. The invoices must be approved by TennCare and contain information sufficient to minimize disputes and comply with supplemental rebate contracts with the manufacturers.		Penalty will be $1,000 per invoice per day invoice overdue.
E.4.a.(2) Breach, Partial Default	In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall	Contract Performance Standard	The amount of liquidated damages assessed against the Contractor shall be at the discretion of the State, in accordance with the specific penalty provisions contained

	begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor. In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount. The State may assess Liquidated Damages on the Contractor in accordance with the penalty provisions contained herein for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.		in the base Contract and this Amendment, and not exceed 10% of the maximum payments previously made by TennCare to Contractor

Timely implementation of the above cost containment measures, and assessment by TennCare of any penalties for Contractor's failure to do so, are contingent upon the following:

- TennCare staff being available to support each initiative in the form of timely review, approval and oversight
- TennCare staff being responsible for all interactions with CMS to receive program approvals
- TennCare ansuring that its MMIS contractor provides system modifications to support the implementation of the cost containment program

For all file interfaces, any changes to the file format, schedule, or media type will go through the full Change Control, testing, and be signed-off by TennCare and Contractor.

Receipt of the weekly files may be rescheduled upon agreement of both parties without damages being incurred.

ATTACHMENT B
TennCare Contract Amendment Pricing

Initiative	Sub-Initiative	Implementation Fee (1)	Pre-Operational Call Center Fee (per Week) (2)	Monthly Administrative Fee (3)	Call Center Rates (4)			
					Fee Per Non-Clinical Resolution	Grier-compliant Clinical Prior Authorizations		
						Rx Technician	Pharmacist	Physician
Administrative Edits	DEA Number Edit	79,514	N/A	-	3.55	N/A	N/A	N/A
	Prescriber Last Name Edit	145,079	N/A	-	3.55	N/A	N/A	N/A
	Drug to Gender Edit	69,086	N/A	-	N/A	N/A	15.15	44.80
	Gross Amount Due Edit	165,362	N/A	-	3.55	N/A	N/A	N/A
	Maximum Dollar Amount Edit	69,086	N/A	-	N/A	N/A	15.15	N/A
	Unit of Measure Edit	121,926	N/A	-	N/A	7.22	N/A	N/A
	MAC/DAW	95,157	11,015	-	N/A	7.22	N/A	N/A
Clinical Edits	Drug Dosage & Dose Optimization Edit	78,397	10,246	-	N/A	7.22	15.15	44.80
	Drug Duplication of Therapy Edit	229,233	55,326	-	N/A	7.22	15.15	44.80
	Drug-Drug	224,763	47,130	-	N/A	7.22	15.15	44.80

	Interaction Edit							
	Drug Duration Edit	78,397	2,049	-	N/A	7.22	15.15	44.80
	Drug-to-Disease Edit	78,397	4,098	-	N/A	7.22	15.15	44.80
	OTC Class Elimination	75,045	N/A	-	3.55	N/A	N/A	N/A
Step Therapy		215,080	45,080	-	N/A	7.22	15.15	44.80
Script Limit Edits	Hard Limit for Non-Exempts	159,231	29,870	-	3.55	N/A	N/A	N/A
Tiered Co-pay Edits		173,445	1,102	-	3.55	N/A	N/A	N/A
MAC		49,645	N/A	-	3.55	N/A	N/A	N/A
Additional Dedicated Staff (5)	1 Clinical Pharmacist based in Nashville			13,469				
	2 Provider Educator Pharmacists based in Nashville			22,358				
	1 Pharmacy Research Scientist			15,650				
	1 Data Quality Analyst based in Nashville			9,216				
	1 Systems Liaison based in Richmond			12,587				
	1 Contract Manager based in Richmond			12,619				
	1 Business Analyst based in Richmond			7,173				
	1 Reform Project Manager based 25% in Nashville, balance in Richmond			12,256				
	2 Mail Room Clerks (ongoing)			7,244				
	8 Temp Mail Room Clerks (3 months*)			28,976				
RetroDUR (Takeover from UT)		173,136	N/A	45,833				
Equipment		-	N/A	-				
Totals		**2,279,979**	**205,915**	**187,381**				

Notes:

(1) The Call Center Planning and Development deliverable is payable for each initiative upon notice from TennCare to begin implementation of the phase in which the edit resides. Other subcomponents of the implementation fee are payable upon TennCare receipt and approval of the associated deliverable. (see Attachment C)

(2) Pre-operational call center fees are payable for each initiative (and sub-initiative, as applicable) in the event that TennCare delays the "go live" date. These fees shall begin on the planned "go live" date and cease when the edit actually does "go live" (i.e.hard-edits become fully operational and call center rates become effective) or when TennCare gives notice to cancel the initiative. The "go live" date is specified in the contract as the "date to complete implementation", except as it relates to the Script Limit and Tiered Co-pays. For these groups of edits, the "go live" date shall be communicated in writing by TennCare to First Health no less than 6 weeks prior to the intended "go live" date.

(3) Monthly administrative fees are payable for each initiative (and sub-initiative, as applicable) upon First Health Services' written notice to TennCare that the initiative is operational or that additional dedicated staff are hired, as applicable. Partial months shall be prorated.

(4) PDL related prior authorizations are covered under the base contract. For the initiatives added via Amendment Two, prior authorizations will be billed on a "per resolution" basis. If multiple calls are required to resolve a given issue (e.g. issue a Prior Authorization), the Contractor will only bill for a single unit of the highest level call that took place.

(5) Any System Change Requests made by TennCare and not explicitly described in this Amendment will be billable to TennCare at a rate of $150 per hour.

* The 8 temporary mail room clerks will be added for a three month period to process returned mail associated with the reissuing of ID cards of the TennCare population if such reissuing is directed by TennCare.

ATTACHMENT C

Implementation Deliverables List

Initiative/Sub-Initiative	Deliverable	Fee
DEA Number Edit	Call Center Planning and Development	$ 79,514
Prescriber Last Name Edit	Call Center Planning and Development	$ 78,397
	System Coded to Edit on Last Name and Approved by TennCare	$ 66,682
Drug to Gender Edit	Call Center Planning and Development	$ 69,086
Gross Amount Due Edit	Call Center Planning and Development	$ 83,984
	System Coded to Edit on Gross Amount Due and Approved by TennCare	$ 81,378
Maximum Dollar Amount Edit	Call Center Planning and Development	$ 69,086
Unit of Measure Edit	Call Center Planning and Development	$ 69,086
	System Coded to Edit on Unit of Measure and Approved by TennCare	$ 52,840
MAC/DAW	Call Center Planning and Development	$ 95,157
Drug Dosage & Dose Optimization Edit	Call Center Planning and Development	$ 78,397
Drug Duplication of Therapy Edit	Call Center Planning and Development	$ 229,233
Drug to Drug Interaction Edit	Call Center Planning and Development	$ 224,763
Drug Duration Edit	Call Center Planning and Development	$ 78,397
Drug to Disease Edit	Call Center Planning and Development	$ 78,397
Step Therapy	Call Center Planning and Development	$ 215,080
OTC Class Elimination	Call Center Planning and Development	$ 37,523
	System Coded to appropriately deny OTC medications for affected recipients	$ 37,522
Script Limit Edits	Call Center Planning and Development	$ 80,632
	Requirements Defined and Documented in TennCare-Approved CSA	$ 39,300
	System Coded to Edit on Script Limit Criteria and Approved by TennCare	$ 39,300
Tiered Co-pay Edits	Call Center Planning and Development	$ 75,045
	Requirements Defined and Documented in TennCare-Approved CSA	$ 49,200
	System Coded to Edit on Tiered Copays and Approved by TennCare	$ 49,200
MAC	Call Center Planning and Development	$ 15,621
	Requirements Defined and Documented in TennCare-Approved CSA	$ 34,024
RetroDUR (Takeover from UT)	Plan Delivery	$ 98,136
	Requirements Defined and Documented in TennCare-Approved CSA	$ 25,000
	Year-one RetroDUR Plan Submitted to TennCare	$ 25,000
	DUR Board Members Recruited and Trained	$ 25,000
Total		**$2,274,021**